



THE COMMONWEALTH OF MASSACHUSETTS State Board of Retirement

ONE ASHBURTON PLACE, BOSTON, MA 02108-1607

JUDICIAL RETIREMENT APPLICATION

APPLICATION PROCESS

If you are actively employed or on a leave of absence you may file your application to retire no earlier than 120 days before you plan to retire. If you file more than sixty days after your last day on payroll, your benefits will not be retroactive to your last day paid. Your effective date of retirement will be 15 days from receipt of your application.

The State Retirement Board strongly recommends that you plan your retirement and that you file at least 30 to 60 days in advance of leaving your job. Once your effective date of retirement has passed, you cannot change your retirement option nor can you change your date of retirement.

COUNSELING

If you are interested in individual counseling, walk in counseling service is available at the State Board of Retirement at our main office located at One Ashburton Place, Room 1219 in Boston or our regional office located at 436 Dwight Street, Room 109A in Springfield, from 7:45 a.m. to 5:00 p.m., Monday through Friday.

Phone: (617) 367-7770 (Boston) or (413) 730-6135 (Springfield) **Toll Free:** 1-800-392-6014 (Mass only)
Fax: (617) 723-1438 **Website:** www.mass.gov/treasury/srb.htm

APPLICATION PROCESS CHECKLIST

When filing your retirement application, please include the following documents:

- ☐ Fully completed application (complete page 2).
- ☐ One completed Option Selection Form A, B, or C (complete pages 2, 3, or 4).
- ☐ W-4P Federal Tax Withholding Form indicating withholding amount for federal income purposes (complete page 6).
- ☐ Copy of Birth Certificate.
- ☐ If you are taking Option C, a copy of the beneficiary's birth certificate, and a copy of the marriage license if the beneficiary is the applicant's spouse. If the beneficiary is a former spouse, the spouse must be unmarried as of the date of retirement.

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JUDICIAL RETIREMENT APPLICATION

I respectfully request retirement under the provisions of Section 65A, B, D or H of Chapter 32 of the Massachusetts General Laws.

SS#:	
I wish to retire on:	with years and months of service.
Name:	
Age as of retirement date:	(Copy of Birth Certificate Required)
Present Address: (No., Street, P.O. Box)	
City, State, Zip:	
Address after retirement, if different: (No., Street, P.O. Box)	
Home Phone: ()	Work Phone: ()
Married (Y/N)	If married, spouse's age:
I am currently Serving at:	Court, Date of Appointment:

▶ LIST ANY OTHER GOVERNMENTAL SERVICE*
INCLUDE ALL SERVICE, STATE, COUNTY OR CITY. ATTACH ADDITIONAL SHEETS, IF NECESSARY

Department or Subdivision	Start Date	Date Service Ended	Did You Take a Refund of Your Account? Y/N

* Note - If you have 10 or more years of non-judicial service you may be eligible for a separate pension subject to the provisions of Sec 5 or 10 of Chapter 32.

▶ The above is a true statement made under the penalties of perjury	
_____ (Signature)	_____ (Date)



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OPTION SELECTION FORM:

OPTION A

**THERE ARE NO SURVIVOR
RETIREMENT BENEFITS**

I request my pension be paid in accordance with Option A as provided in Section 65A, B, D, or H of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, UPON MY DEATH, I RELINQUISH ALL CLAIMS TO THE TOTAL CONTRIBUTIONS AND THE TOTAL INTEREST THAT HAVE BEEN CREDITED TO MY ACCOUNT. My Designated Beneficiary(ies) listed below will receive only a prorated amount for the number of days I live in the month of my death.

THERE ARE NO SURVIVOR BENEFITS.

BENEFICIARY(IES) INFORMATION (MUST BE COMPLETED)

1	Name:	Designation:	Proportion:	Date of Birth:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	Beneficiary Social Security Number:
2	Name:	Designation:	Proportion:	Date of Birth:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	Beneficiary Social Security Number:
3	Name:	Designation:	Proportion:	Date of Birth:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	Beneficiary Social Security Number:
4	Name:	Designation:	Proportion:	Date of Birth:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	Beneficiary Social Security Number:
5	Name:	Designation:	Proportion:	Date of Birth:
	Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
	City, State, ZIP:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	Beneficiary Social Security Number:

► **MEMBER INFORMATION**

(Print Name)

(Social Security Number)

(Signature)

(Date)

► **SIGNATURE OF WITNESS** - THIS OPTION FORM MUST BE WITNESSED.
IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

(Print Name)

(Address/City/Town/State/Zip)

(Signature)

(Date)



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OPTION SELECTION FORM:

OPTION B

**LUMP SUM PAYMENT TO
BENEFICIARY IN EVENT OF
EARLY DEATH**

I request my pension be paid in accordance with Option B as provided in Section 12, subsection 2 of Chapter 32, if retiring under 65H.

I UNDERSTAND BY CHOOSING THIS OPTION, I WILL RECEIVE A REDUCED MONTHLY RETIREMENT ALLOWANCE FOR LIFE. I ALSO UNDERSTAND THAT UPON MY DEATH, IF THERE IS A REMAINING BALANCE IN MY ACCOUNT - DEPOSITS AND INTEREST - IT WILL BE REFUNDED TO MY BENEFICIARY(IES) OR ESTATE IN A LUMP SUM. THE DESIGNATED BENEFICIARY(IES) WILL ALSO RECEIVE A PRORATED AMOUNT FOR THE NUMBER OF DAYS I LIVE IN THE MONTH OF MY DEATH. I UNDERSTAND THAT THE ANNUITY PORTION OF MY ALLOWANCE IS REDUCED EACH MONTH. IF MY ANNUITY SAVINGS ACCOUNT IS DEPLETED AT TIME OF MY DEATH, I UNDERSTAND THAT THERE WILL BE NO SURVIVOR BENEFIT.

BENEFICIARY(IES) INFORMATION (MUST BE COMPLETED)

1	Name:	Designation: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Proportion: <input type="checkbox"/> All <input type="checkbox"/> _____ % (Percent)	Date of Birth:
	Street:			Relationship:
	City, State, ZIP:			Beneficiary Social Security Number:
2	Name:	Designation: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Proportion: <input type="checkbox"/> All <input type="checkbox"/> _____ % (Percent)	Date of Birth:
	Street:			Relationship:
	City, State, ZIP:			Beneficiary Social Security Number:
3	Name:	Designation: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Proportion: <input type="checkbox"/> All <input type="checkbox"/> _____ % (Percent)	Date of Birth:
	Street:			Relationship:
	City, State, ZIP:			Beneficiary Social Security Number:
4	Name:	Designation: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Proportion: <input type="checkbox"/> All <input type="checkbox"/> _____ % (Percent)	Date of Birth:
	Street:			Relationship:
	City, State, ZIP:			Beneficiary Social Security Number:
5	Name:	Designation: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Proportion: <input type="checkbox"/> All <input type="checkbox"/> _____ % (Percent)	Date of Birth:
	Street:			Relationship:
	City, State, ZIP:			Beneficiary Social Security Number:

► **MEMBER INFORMATION**

(Print Name)

(Social Security Number)

(Signature)

(Date)

► **SIGNATURE OF WITNESS** - THIS OPTION FORM MUST BE WITNESSED.
IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

(Print Name)

(Address/City/Town/State/Zip)

(Signature)

(Date)



I request my pension be paid in accordance with Option C as provided in Section 12, subsection 2 or in Section 65C of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, I WILL RECEIVE A REDUCED MONTHLY RETIREMENT ALLOWANCE FOR LIFE. I ALSO UNDERSTAND THAT MY NAMED BENEFICIARY WILL RECEIVE TWO-THIRDS OF MY RETIREMENT ALLOWANCE UPON MY DEATH FOR HIS OR HER LIFETIME, AND I UNDERSTAND SHOULD THE NAMED BENEFICIARY PRE-DECEASE ME, MY ALLOWANCE WILL REVERT TO OPTION A. AN ELIGIBLE BENEFICIARY MAY BE A SPOUSE, FORMER SPOUSE (unmarried at date of retirement), CHILD, FATHER, MOTHER, BROTHER, OR SISTER.

BENEFICIARY(IES) INFORMATION (MUST BE COMPLETED)

Name:	
Date of Birth:	
SS#:	
Relationship to member:	
Gender:	

PLEASE INCLUDE A COPY OF BIRTH CERTIFICATE OF BENEFICIARY AND A COPY OF MARRIAGE CERTIFICATE, IF SPOUSE.

MEMBER INFORMATION

(Print Name)

(Social Security Number)

(Signature)

(Date)

SIGNATURE OF WITNESS - THIS OPTION FORM MUST BE WITNESSED.
IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

(Print Name)

(Address/City/Town/State/Zip)

(Signature)

(Date)



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RETIREE'S WITHHOLDING
PREFERENCE CERTIFICATE:
W-4P TAX FORM

► **MEMBER INFORMATION**

(Print Name)

(Social Security Number)

(Signature)

(Date)

PLEASE CHECK THE APPROPRIATE BOX:

1

☐

I do not wish to have federal tax withheld from my benefit. I realize that I am liable for payment of federal income tax on the taxable portion of my pension and that I may be subject to pay penalties under the estimated tax payment rules if my payments of estimated tax and withholding are not adequate.

2

☐

The following exemptions are being claimed and I wish to have the Plan Administrator determine the amount, if any, of federal income tax to be withheld in accordance with the tax tables and exemptions claimed below.

A) Marital Status

☐

Single

☐

Married

☐

Married, but withhold at higher single rate _____

B) Total exemption you wish to claim: _____

C) In addition to the above amount, withhold an additional \$ _____ per month.

3

☐

I wish to have a flat rate of \$ _____ per month withheld.

► **SIGNATURE OF RETIREE**

(Signature)

(Date)

Note: Non-contributory pensions for judges appointed prior to 1/1/75 or sitting on the Supreme Judicial Court pay both State and Federal taxes.



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